# SEER SINQ'S

# FINALIZED JANUARY 2011

## Question: 20110024

**Status**
Provisional

**Question**
MP/H Rules/Histology--Breast: Which histology code and rule should be used to code a breast primary with a diagnosis of ductal carcinoma in situ with clear cell features? See discussion.

**Discussion**
None of the histology rules for in situ breast seem to apply. H3 doesn't seem to apply because clear cell is not a specific intraductal carcinoma. H6 doesn't seem to apply because there is not a combination of intraductal and 2 or more specific types of intraductal. H8 wouldn't apply because one of the types is intraductal.

**Answer**
Code 8523/2, intraductal carcinoma mixed with other types of in situ carcinoma. Rule H6 should apply here, but the wording needs to be clarified. This will be done in the next revision of the rules.

**History**

**Last Updated**
01/31/11

## Question: 20110023

**Status**
Final

**Question**
Multiple primaries--Heme & Lymphoid Neoplasms: For this case, what is correct -- single primary or multiple primaries? See discussion.

**Discussion**

Refractory anemia, nos diagnosed in November 2009. A bone marrow performed on 10/25/10 reads Myelodyplastic syndrome - refractory anemia with excess blasts type 2 with ringed sideroblasts. The medical oncologist in his 12/16/10 clinic note states "Pt underwent bone marrow on 10/25/10 and ultimately this marrow demonstrates progression to AML.

When I apply the Hematopoietic Rules, the refractory anemia, nos and the myelodysplastic syndrome - refractory anemia with excess blasts type 2 with ringed sideroblasts is the same primary but the refractory anemia nos and the AML are multiple primaries.

**Answer**

First, note that MDS is a group term that includes a number of diseases, one of which is refractory anemia with ringed sideroblasts. The MDS noted on the bone marrow is reflective of some cells that do not show the refractory anemia. These two diseases are an NOS and a more specific disease, one primary.

Next, assess the change from refractory anemia to AML. When you look at the Hematopoietic DB, AML is listed under transformations for refractory anemia with ringed sideroblasts. That means you have a chronic disease (refractory anemia with ringed sideroblasts) and an acute disease (AML). See the Multiple Primary Rules M10. Abstract as multiple primaries when a neoplasm is originally diagnosed in a chronic (less aggressive) phase AND second diagnosis of a blast or acute phase more than 21 days after the chronic diagnosis.

Conclusion: Abstract the AML as a second primary. This is confirmed by entering refractory anemia with ringed sideroblasts and AML in the Multiple Primaries Calculator.

**History**

**Last Updated**

01/28/11

## Question: 20110022

**Status**

Final

**Question**

Histology--Heme & Lymphoid Neoplasms: What histology code would you use for follicular lymphoma, grade I-II/III, predominate follicular pattern?

**Discussion**

**Answer**
This means the lymphoma is between a grade 1 and 2 of three possible grades. Code to the higher grade, code the histology follicular lymphoma grade 2.

**History**

**Last Updated**
01/19/11

## Question: 20110021

**Status**
Final

**Question**
First course treatment--Heme & Lymphoid Neoplasms: Would a stem cell transplant be treatment for a Multiple Myeloma? It is not listed under Treatments for this disease in the database.

**Discussion**

**Answer**
Yes, stem cell transplant is a new treatment for MM. It will be added to the DB in the next revision.

**History**

**Last Updated**
01/19/11

## Question: 20110020

**Status**
Final

**Question**
Heme & Lymphoid Neoplasms: If a patient is diagnosed with MDS and receives treatment, then the MDS later transforms to AML (now it is 2 primaries), what is the cancer status of the MDS?

**Discussion**

**Answer**
If the bone marrow no longer shows evidence of MDS, the cancer status for the MDS is disease-free. Cancer status coded disease-free (NED) means that currently there is no clinical evidence of this disease (MDS).

**History**

**Last Updated**
01/19/11

## Question: 20110019

**Status**
Final

**Question**
Multiple primaries/Laterality--Heme & Lymphoid Neoplasms: Lymphoma of bilateral testes. Is this abstracted as multiple primaries or single primary with laterality coded to bilateral?

**Discussion**

**Answer**
Lymphoma of bilateral testes is a single primary. See the Multiple Primary rules, M2. Abstract as a single primary when there is a single histology.

**History**

**Last Updated**
01/19/11

## Question: 20110018

**Status**
Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: The patient had Follicular Lymphoma Grade 2 and was treated over a period of time. The Oncologist thinks the spleen is congested & removes the spleen. Pathology finds Diffuse Large B-cell Lymphoma in the spleen. Is DLBCL a second primary & why?

**Discussion**

**Answer**
The diffuse large B-cell lymphoma (DLBCL) is a new primary. To determine the answer, do the following:

Step 1. Search the DB for follicular lymphoma, grade II 9698/3. Look at the transformation information. The DB says FL transforms to DLBCL, which means you have a chronic neoplasm (FL) that has transformed to an acute neoplasm (DLBCL).

Step 2: Go to the MP Rules, M10: Abstract as multiple primaries when a neoplasm is originally diagnosed in a chronic (less aggressive) phase AND second diagnosis of a blast or acute phase more than 21 days after the chronic diagnosis.

**History**

**Last Updated**
01/19/11

## Question: 20110017

**Status**
Final

**Question**
Multiple primaries--Heme & Lymphoid Neoplasms: Patient was originally diagnosed with CLL and then a few months later after a bone marrow biopsy, was diagnosed with Richter's syndrome and it was transformed into a large cell lymphoma. How do I put this case in? I read the resources that state this is a very rare condition, so is this a case where I leave it under CLL or change it to a large cell lymphoma?

**Discussion**

**Answer**
This is a new primary, diffuse large B-cell lymphoma (DLBCL) 9680/3. Richter syndrome (RS) is a complication of B cell chronic lymphocytic leukemia (CLL) or hairy cell leukemia

(HCL) in which the leukemia changes into DLBCL. There is also a less common variant in which the CLL changes into a Hodgkin lymphoma. Richter's transformation affects about 5% of CLL patients.

**History**

**Last Updated**
01/19/11

## Question: 20110016

**Status**
Provisional

**Question**
Behavior--Brain and CNS: Can hemangioblastomas occurring the in CNS be coded to a /3, malignant, behavior? See discussion.

**Discussion**
Hemangioblastomas are borderline (/1) according to ICD-O. The standard matrix rule in ICD-O directs registrars to change the behavior code to malignant when a malignant (/3) behavior is stated by a physician to a morphology code that appears in ICD-O with a non-malignant behavior code. The "malignant" hemangioblastomas we see are not pathologically confirmed; they are radiological or clinical diagnosis confirmed with renal cell carcinoma being one of the malignant differential diagnoses.

**Answer**
The behavior code for hemangioblastoma can be coded to /3 when a pathologist indicates that the behavior is malignant. The behavior code should be based on a pathologist's opinion. It is usually not possible for another physician to make this determination.

The histologic appearance of hemangioblastoma may resemble metastatic renal cell carcinoma; therefore, you will often see renal cell carcinoma listed as a possible diagnosis. This does not indicate that the hemangioblastoma is malignant. Do not code the behavior as /3 based on a differential diagnosis of renal cell carcinoma.

**History**

**Last Updated**
01/28/11

## SEER SINQ'S

## FINALIZED JANUARY 2011

### Question: 20110014

**Status**
Final

**Question**
MP/H/Histology--Corpus Uteri: Which MP/H rule applies in coding histology with a tumor described by the pathologist as "high grade endometrioid adenocarcinoma with squamous differentiation (adenosquamous carcinoma)"? See discussion.

**Discussion**
Is the pathology description a specific histology (adenosquamous carcinoma, histology code 8560/3)? Or is it a combination/mixed histology? If it is mixed, would MP/H rule H16 apply? H16 instructs us to code a mixed code from Table 2 (endometrioid and squamous combines into mixed cell adenocarcinoma, histology code 8323/3)?

**Answer**
Rule H11 applies. Endometrioid adenocarcinoma with squamous differentiation is coded 8570 [Adenocarcinoma with squamous metaplasia].

**History**

**Last Updated**
01/30/11

### Question: 20110013

**Status**
Provisional

**Question**
MP/H Rules/Histology--Testis: Which MP/H rule applies in coding the histology described as a "malignant mixed germ cell tumor with the following features: Histologic type: embryonal carcinoma (97%) and yolk sac tumor (3%)"? See discussion.

**Discussion**
Per MP/H Rule H16, code the appropriate combination/mixed code (Table 2) when there are multiple specific histologies or when there is a non-specific histology with multiple specific histologies, but the combination of embryonal carcinoma and yolk sac tumor is not listed in Table 2. Would Rule H17 (Code the histology with the numerically higher ICD-O-3 code) apply instead?

**Answer**

Assign 9065/3, Germ cell tumor, nonseminomatous. Our pathologist consultant's comments for this code: Code 9065 is listed by ICDO as germ cell tumor, nonseminomatous. This is a generic code for any germ cell tumor not containing seminoma.

**History**

**Last Updated**
01/28/11

## Question: 20110012

**Status**
Final

**Question**
Reportability--Sarcoma: Is the final diagnosis for a soft tissue excision described by the pathologist as an "atypical lipomatous tumor/well-differentiated liposarcoma" reportable? See discussion.

**Discussion**
In this case, the COMMENT section states, "Atypical lipomatous tumor/well differentiated liposarcoma has a significant risk for local recurrence, but no metastatic potential." Per 2010 SPCSM, page 3, example 4: The pathologist makes the final decision about the behavior for a particular case. In this case, the pathologist uses both a reportable and a non-reportable term in the final diagnosis and in the comment section of the pathology report. Does the pathologist's comment in any way impact how we should code the behavior and reportability of this tumor?

**Answer**
Atypical lipomatous tumor/well-differentiated liposarcoma is reportable. This terminology comes directly from the WHO Classification of Tumours of Soft Tissue and Bone. According to WHO, atypical lipomatous tumor/WD liposarcoma is a locally aggressive malignant mesenchymal neoplasm.

**History**

**Last Updated**
01/24/11

## Question: 20110011

**Status**
Final

**Question**
Reportability--Heme & Lymphoid Neoplasms: Is a 2010 diagnosis of thrombocytopenia of unknown etiology reportable? Because thrombocytopenia is a new "buzz-word", I looked it up in the Hemato database. When I enter the term "thrombocytopenia of unknown etiology" I receive 22 results, and when I enter just the term "thrombocytopenia" I receive 1 result of Refractory thrombocytopenia.

**Discussion**

**Answer**
This diagnosis is not reportable. Thrombocytopenia is a low platelet count which causes bleeding. Thrombocytopenia can be caused by viral infections, excessive alcohol usage, HIV, and other causes (including chemotherapy). If the diagnosis is not "refractory thrombocytopenia" the case is not reportable. When searching for a diagnosis, do not put the entire diagnosis "thrombocytopenia of unknown etiology" into the search engine. Your second search on the word thrombocytopenia is the correct way to search. If you do not see the term in the Hemato DB, it is not reportable.

**History**

**Last Updated**
01/10/11

## Question: 20110010

**Status**
Final

**Question**
Multiple primaries--Heme & Lymphoid Neoplasms: 6/10/10 Axillary lymph node biopsy compatible with AML and MD says patient was recently diagnosed with granulocytic sarcoma in the axillary node. 6/15/10 BM biopsy compatible with AML FAB 1. After induction 2nd BM biopsy on 6/30/10 shows persistent/refractory AML. MD says the 2nd biopsy is compatible with AML FAB M7. Is the granulocytic sarcoma a chronic form of the disease? If so do we have one primary? Diagnosed 6/10/10 Primary C42.1 with histo code 98783/3? (based on rule M7) Is the 2nd biopsy on 6/30/10 the same primary even though the persistent disease is now FAB M7?

**Discussion**

**Answer**
Granulocytic/myeloid sarcoma is a solid manifestation of AML. When these diagnoses occur simultaneously (at the same time or within 21 days of each other) they are coded as a single primary, AML. The FAB category is an older classification that is seldom used, but changes from FAB 1 to FAB 7 do not constitute a new primary. This is a single primary coded to AML and bone marrow.

**History**

**Last Updated**
01/10/11

## Question: 20110009

**Status**
Final

**Question**
Diagnostic confirmation/Date of diagnosis--Heme & Lymphoid Neoplasms: Bone marrow biopsy done on 2/11/10: mild trilineal dysplastic changes in conjunction with chronicity of cytopenias is worrisome for MDS. Cytogenetics + for 5q deletion, clinicopathologic correlation required for final diagnosis. On 2/25/10 Dr confirms Refractory cytopenia with multilineage dysplasia. Is the date of diagnosis 2/11/10 with diagnostic confirmation of 3 or 2/25/10 w with diagnostic confirmation of 8?

**Discussion**

**Answer**
The date of diagnosis is 2/25/10 and diagnostic confirmation is 8. As the cytogenetics state, you need clinicopathologic correlation to get an actual diagnosis; there is no actual diagnosis from the bone marrow. The cytogenetics were done (the pathologic part) and then the physician confirmed refractory cytopenia with multilineage dysplasia 9985/3 (the clinical part). The actual diagnostic process and diagnosis were completed when the clinician made the statement that this is refratory cytopenia with multilineage dysplasia.

**History**

**Last Updated**

01/10/11

## Question: 20110008

**Status**
Final

**Question**
MP/H/Histology--Vulva: How should histology be coded for "VIN III with focal invasion"? See discussion.

**Discussion**
Per SINQ 20000442, CIN III with microinvasion is to be coded to 8077 [squamous intraepithelial neoplasia, grade III] per the matrix system rules, with a behavior code of 3 [malignant]. For this case, we used the matrix principle and coded histology to 8077 with behavior of 3. This caused IF25_3 and MorphICDO3_P1 edits to fail. We can flag the case to resolve the first error but we do not know how to resolve the MorphICDO3_P1 edit.

**Answer**
Assign 8076/3 [squamous cell carcinoma, microinvasive] for VIN III with focal invasion. This applies to all terminologies listed under 8077/2. The sinq question from 2000 will be retired.

**History**

**Last Updated**
01/28/11

## Question: 20110007

**Status**
Final

**Question**
MP/H Rules/Multiple primaries--Bladder: How many primaries are represented and how should histology be coded when a bladder resection shows a tumor with invasive small cell neuroendocrine carcinoma (8041/3) with high-grade papillary urothelial carcinoma in situ (8130/2), adenocarcinoma in situ (8140/2) along with multifocal flat urothelial carcinoma in situ? See discussion.

**Discussion**

Are the areas of in situ tumor to be ignored or would MP/H Rule M9 apply?

**Answer**
Ignore the in situ histologies. This is a single primary. Code invasive small cell neuroendocrine carcinoma (8041/3).

**History**

**Last Updated**
01/24/11

## Question: 20110006

**Status**
Final

**Question**
Reportability/Heme & Lymphoid Neoplasms: Are all stages of CLL reportable? We have a few cases where the physician notes the patient has Stage 0 CLL (increasing leukocytosis). When we Googled CLL Stage, we found Stage 0, I, II, III, and IV. CLL Stage is not mentioned in the new hematopoietic rules (database or manual).

**Discussion**

**Answer**
Yes, all stages of CLL are reportable. CLL has a unique staging system. Since the Hematopoietic DB and Manual do not address stage, we did not include this information in the abstractor notes.

**History**

**Last Updated**
01/10/11

## Question: 20110005

**Status**
Final

**Question**
Multiple primaries/Histology--Heme & Lymphoid Neoplasms: I have a question regarding

the original histology coding for a case. Patient came to our facility in 2010, same primary as original diagnosis in 2006; no reporting for our facility. However, we also abstract for another hospital and this was their 2006 case.

Outside consult diagnosis: Follicular Gr 2 NHL with Marginal Zone B-Cell Differentiation.

Abstractor coded this to Marginal Zone Lymphoma in 2006.

My question: Would you ignore the differentiation statement in 2006? I do know now in 2010, Follicular Gr 2 Lymphoma 9691/3 and Marginal Zone B-Cell Lymphoma are different primaries (as they were in 2006 on the paper chart).

I am trying to figure out if I need to correct this case or not, but I cannot find information regarding how "differentiation" was handled in the previous hematopoietic scheme.

**Discussion**

**Answer**
This is a reportable case for 2006.

For diagnoses in 2010 and forward, a small number of cases of follicular lymphoma do have marginal zone differentiation. There is no code for this variant of follicular lymphoma, it is simply coded as follicular lymphoma since that is the most accurate histology code available. The marginal zone differentiation should not be coded as a second primary (marginal zone lymphoma).

**History**

**Last Updated**
01/10/11

## Question: 20110004

**Status**
Final

**Question**
MP/H Rules/Histology--Breast: Which MP/H rule applies when coding the histology field for a tumor described as a "metaplastic carcinoma, adenosquamous and spindle cell type"? See discussion.

**Discussion**

Per path comment: "The neoplasm is composed of adenosquamous carcinoma which merges with spindle cell carcinoma. The cystic component shows a mixed squamous and ductal epithelial lining which shows cytologic atypia and mitotic activity and can be seen to merge with invasive carcinoma. The features suggest the possibility that the tumor may have arisen from a sclerosing and cystic papilloma with squamous metaplasia, although a clearly benign component is not evident."

Would MP/H rule H19 apply based on the path comment, in which case histology would be coded 8255 (adenocarcinoma with mixed subtypes)? Or, based on the final diagnosis, would MP/H rule H14 apply because adenosquamous and spindle cell are not specific types of metaplastic carcinoma? Using rule H14 is the histology coded to 8575 (metaplastic carcinoma)?

**Answer**
This is a metaplastic carcinoma as stated in the path diagnosis. Rule H14 applies. Assign code 8575/3. According to the WHO Classification, metaplastic carcinoma is a general term for a group of neoplasms characterized by a mixture of adenocarcinoma with dominant areas of spindle cell, squamous, and/or mesenchymal differentiation.

**History**

**Last Updated**
01/24/11

## Question: 20110003

**Status**
Final

**Question**
MP/H Rules/Histology--Colon: Which MP/H rule applies when coding the histology field for a tumor described as a "large cell neuroendocrine carcinoma (arising in adenocarcinoma)"? See discussion.

**Discussion**
Per path comment: "In addition to usual adenocarcinoma, a significant portion of this tumor displays features consistent with large cell neuroendocrine carcinoma, an aggressive neoplasm which has a poorer prognosis than adenocarcinoma of comparable stage." Would histology code 8574/3 (adenocarcinoma with neuroendocrine differentiation) be the appropriate code for this case? Which MP/H rule applies?

**Answer**
Rule H8 applies. Assign code 8244. WHO describes these as "Mixed

adenoneuroendocrine carcinoma (MANEC)." They have components of adenocarcinoma mixed with high-grade NEC, which can be either small cell or large cell. The next version of the MP/H rules for colon will make this more clear.

**History**

**Last Updated**
01/24/11

## Question: 20110002

**Status**
Final

**Question**
Surgery of Primary Site--Penis: How would I code CO2 laser treatment for cancer of the penis?

**Discussion**

**Answer**
Assign code 14, laser, for CO2 laser treatment given for primary penile cancer. The C02 is the method used to deliver the laser.

**History**

**Last Updated**
01/10/11

## Question: 20110001

**Status**
Final

**Question**
Histology--Heme & Lymphoid Neoplasms: How should histology be coded for acute myeloid leukemia with monocytic differentiation?

**Discussion**

**Answer**
Code as acute myeloid leukemia. The monocytic differentiation is refering to glycoproteins expressed on cells of the myelomonocyte lineage including monocytes, macrophages, and some granulocytes.

**History**

**Last Updated**
01/10/11

## Question: 20100114

**Status**
Final

**Question**
Primary site/Histology--Heme & Lymphoid Neoplasms: Myeloid sarcoma of the pancreas was diagnosed by a Whipple on June 10th. A bone marrow was performed on June 22nd which confirmed an AML. Should I use Module 5 PH15 to code to C25.9 and 9930/3? There is no comment in this module if the bone marrow is involved and PH14 indicates limited to bone marrow only.

**Discussion**

**Answer**
When you have unusual presentations as exhibited by this case, always use the abstractor notes. As the abstractor notes for myeloid sarcoma state, this disease may occur in any organ and often occurs simultaneously with AML. There are two primaries, myeloid sarcoma with a primary site of pancreas and AML with a primary site of bone marrow.

**History**

**Last Updated**
01/10/11

## Question: 20100113

**Status**
Final

**Question**
Reportability--Heme & Lymphoid Neoplasms: Is Hemophagocytic lymphohistiocytosis reportable?

**Discussion**

**Answer**
No, this is not a reportable hematologic condition. When you do not find the condition listed in the Hematopoietic DB, it is not reportable. Hemophagocytic lymphohistiocytosis is an uncommon hematologic disorder. The patient usually presents with fever, splenomegaly, and jaundice. Lab findings are lymphocytosis and histiocytosis. Path findings are hemophagocytosis.

**History**

**Last Updated**
01/10/11

## Question: 20100112

**Status**
Final

**Question**
Primary site--Heme & Lymphoid Neoplasms: 2008 diagnosis of mycosis fungoides with over 40 percent of the skin surface involved, both upper and lower extremities and trunk. Is this coded to c448 or c449?

**Discussion**

**Answer**
Code to C449 skin, NOS. C448 should be used for overlapping lesions only. The patient has extensive skin coverage, but it is unlikely that the entire plaque is overlapping.

**History**

**Last Updated**
01/10/11

## Question: 20100111

**Status**
Final

**Question**
Histology--Heme & Lymphoid Neoplasms: The path report states: myeloma plasmablastic variant. What histology code would I use?

**Discussion**

**Answer**
Code as multiple myeloma. The plasmablastic subtype/variant does have a prognostic indication, but the disease is still multiple myeloma.

**History**

**Last Updated**
01/10/11

## Question: 20100110

**Status**
Final

**Question**
Reportability--Esophagus/Stomach: Are the terms "high grade dysplasia" and "severe dysplasia" considered synonymous with in situ for tumors in the gastrointestinal tract? See Discussion.

**Discussion**
SINQ 20000245 states that SEER does not consider high grade or severe dysplasia synonymous with in situ disease. However, per page 109 in the 7th edition of AJCC Cancer Staging Manual, high grade dysplasia is the only term listed under Tis. A note on that page explains that "high-grade dysplasia includes all noninvasive neoplastic epithelia that was formerly called carcinoma in situ, a diagnosis that is no longer used for columnar mucosae anywhere in the gastrointestinal tract." There has been considerable pressure from registrars at larger reporting facilities to re-address this issue. The pathologists at these facilities state that they are correctly documenting the presence of in situ disease when they use the term "high grade dysplasia" for gastrointestinal tract tumors. In their opinion, it is not necessary to add the term "in situ" in parentheses following the use of the term high grade dysplasia to clarify the behavior of these lesions in their pathology

reports. If the term "carcinoma in situ" is no longer being used by many pathologists for sites in the gastrointestinal tract, won't this lead to underreporting of in situ disease for these sites unless we change our reportability guidelines?

**Answer**
The terms "high grade dysplasia" and "severe dysplasia" are not synonymous with in situ for tumors in the gastrointestinal tract. These cases are only reportable when the pathologist documents carcinoma in situ.

Reportability laws are customarily based on ICD-O. Since "high grade dysplasia" and "severe dysplasia" are not designated as in situ in ICD-O, there is no legal authority to report these in most states.

**History**

**Last Updated**
01/28/11

## Question: 20100109

**Status**
Final

**Question**
Reportability–-Ovary: Does the ICD-O-3 term "stromal endometriosis" (8931/3) always imply a reportable malignant disease process if the pathologist also states "no evidence of carcinoma" in the same report? See Discussion.

**Discussion**
ROS Final Diagnosis: LSO: Ovary with an endometriotic cyst (1.2 cm) and stromal endometriosis with multifocal papillary syncytial eosinophilic, clear cell and tubal metaplasia, no evidence of carcinoma. COMMENT: There is extensive endometriosis involving the ovarian stroma and the ovarian surface. The ovarian stroma contains multiple cystic endometrial glands and surrounding endometrial type stroma with variable amounts of hemorrhage. There are non-cystic foci of endometriosis comprised of small, irregular glandular structures within the stroma. The lining of larger cyst/cysts is involved by a single layer of cuboidal to columnar cells with markedly eosinophilic cytoplasm in areas of serous (tubal) metaplasia and papillary projections suggestive of papillary syncytial metaplasia. Within these areas there is epithelial tufting and stratification, raising the consideration of proliferative/borderline change (which we cannot entirely exclude), however, given the background of endometriosis and morphologic similarity to papillary syncytial metaplasia in the endometrium, we favor that this is a non-neoplastic reactive change. There is no evidence of carcinoma.

**Answer**
This case is not reportable. The pathologist states that there is no evidence of carcinoma. The ICD-O-3 matrix system applies, giving the pathologist the final say on behavior.

**History**

**Last Updated**
01/24/11

## Question: 20100108

**Status**
Final

**Question**
MP/H Rules/Histology--Brain and CNS: How is histology coded for a patient diagnosed with a low grade neuroectodermal neoplasm in the left occipital parietal area most consistent with neuronal tumor but lacking classic features of ganglioma. The pathologist says this is not malignant.

**Discussion**

**Answer**
9505/0 [Ganglioglioma, benign] is the best code according to our pathology expert. He states "There recently has been a spate of tumors called low grade glio-neuronal tumors that are not PNETs and have no propensity to become malignant."

**History**

**Last Updated**
01/24/11

## Question: 20100107

**Status**
Final

**Question**
MP/H Rules/Histology--Kidney: What code represents a tumor described as "renal cell carcinoma, clear cell with rhabdoid features"? See discussion.

**Discussion**
Is the statement "with __ features" indicative of a specific type of renal cell carcinoma (that is not represented by a specific histology code) or a second histologic type? Per ICD-O, "malignant rhabdoid tumor" is coded 8963/3. "Rhabdoid" is not listed in Table 1 in the MP/H rules as a specific type of renal cell carcinoma.

**Answer**
Rhabdoid features occur in about 5% of all renal cell cancers and indicate a more aggressive tumor. Per WHO, these tumors comprise aproximately 2% of all pediatric tumors with a median diagnosis age of 1-2 years old. This diagnosis is highly suspect in patients over age 3. Most previously reported rhaboid tumors over age 5 have subsequently proven to be renal medullary carcinomas. If this case is in a child, apply Kidney Rule H7 and code to rhaboid (8963/3). Otherwise, we strongly suggest you consult with the pathologist to determine if this is truely a rhaboid tumor or medullary.

**History**

**Last Updated**
01/24/11

## Question: 20100106

**Status**
Final

**Question**
Reportability-–Bladder: Is a case with a cytology diagnosis of "positive for malignancy, favor low grade papillary urothelial carcinoma" reportable if the diagnosis on a subsequent bladder biopsy showed only "urothelial neoplasm of low malignant potential"? See discussion.

**Discussion**
Patient had urine cytology positive for malignancy, favor low grade papillary urothelial carcinoma on 11/23/09. On 12/28/09 bladder biopsy showed urothelial neoplasm of low malignant potential. SINQ 20081086 only addresses the example of a positive FNA/biopsy followed by a negative resection. Would the previous decision hold for this case when a positive FNA/biopsy is followed by only a negative biopsy?

**Answer**
This case is not reportable. The pathology proved the cytology to be incorrect. The pathologic diagnosis is the "gold standard." When cytology and pathology disagree, use pathology.

**History**

**Last Updated**
01/24/11

## Question: 20100105

**Status**
Final

**Question**
Surgery of Primary Site--Brain and CNS: Is "debulking" of a primary brain tumor subtotal resection of tumor (code 21) or gross resection of tumor (code 30)?

**Discussion**

**Answer**
Assign code 21, subtotal resection of tumor, lesion, or mass. Debulking removes as much of the tumor volume as possible in cases where it is not possible to remove the entire tumor. Debulking should improve the effectiveness of subsequent radiation therapy and/or chemotherapy.

**History**

**Last Updated**
01/24/11